TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pharmacy Express

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-16-0453-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted

Amount in Dispute: $221.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual urges DWC MDR to dismiss Pharmacy Express's request as it is incomplete."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2015	Cyclobenzaprine HCL 10 mg, Meloxicam Tab 7.5mg	$221.04	$221.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 165 – Referral absent or exceeded
   - 855 – Medications not prescribed by or at the direction of the treating Doct or as required by DWC rule

Issues

1. Is the carrier's position statement supported?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states, "Texas Mutual urges DWC MDR to dismiss Pharmacy Express's request as it is incomplete." Review of the submitted documentation finds insufficient information to support a request for reconsideration was made, however submitted information was found to support a referral was made for the services in dispute. Therefore, the dispute request will not be dismissed and the services will be reviewed per applicable rules and fee guidelines.
2. The insurance carrier denied disputed services with claim adjustment reason code 165 – "Referral absent or exceeded and 855 – Medications not prescribed by or at the direction of the treating Doct or as required by DWC Rule." 28 Texas Administrative Code §134.500 (11) states, Prescription--An order for a prescription or nonprescription drug to be dispensed." Review of the submitted information finds;

    a. Referral form dated June 11, 2015 that is signed by treating physician for the services in dispute

    The carrier's denial is not supported. The amount payable will be made with applicable fee guideline.

3. 28 Texas Administrative Code §134.503 (c) states,

    The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

    (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

Date of Service	Prescription Drug	§134.503(c)(1)(A) (AWP per unit) x (number of units) x 1.25 +$4.00	Carrier Paid	Amount Due
June 11, 2015	Cyclobenzaprien HCL 10mg	1.03050 x 30 = 30.92 x 1.25= $38.64 + $4.00= $42.64	$0.00	$42.64
June 11, 2015	Meloxicam Tab 7.5 mg	3.16870 x 60 = 190.12 x 1.25 = $237.64 + $4.00= $241.65	$0.00	$241.65

4. The maximum allowable is $284.29. The requestor is seeking $221.04. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $221.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $221.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.